

## Choices for Care - Case Management, Respite & Companion Services Variance Request Form

- **Instructions:** Case Management services have a maximum allowed number of hours per calendar year. Companion and Respite Care has a maximum service budget per calendar year.
- Complete this form for **individuals** who require additional Case Management hours or an increase in service budget for Companion and Respite Care and meet the variance criteria.
  - Send the request to the contact noted at the bottom of the form. Requests will be reviewed by the Adult Services Division (ASD) at the Disabilities, Aging & Independent Living (DAIL). A new Service Plan is not required. *See additional instructions on back.*
- **Variance Criteria:** A variance will only be approved in situations in which the additional services are necessary to protect or maintain the health, safety or welfare of the individual. (*See CFC Regulations, Section XI.*)
- **Retroactive Requests:** Approved variances are effective no earlier than the date the request was received at DAIL/Adult Services Division. Retroactive requests will be considered only when a precipitating event necessitated an immediate increase of services exceeding the currently approved volume of services. The immediate increase must be necessary to prevent harm to the individual, a hospitalization or nursing facility placement.

**NOTE:** *Prior to approval, DAIL may request additional information including case notes as needed.*

### Completed by Case Manager:

Program (check one): ☐ Moderate Needs ☐ High/Highest

Service (check one): ☐ Case Management ☐ Respite (High/Highest Only) ☐ Companion (High/Highest only)

- |   |                              |
|---|------------------------------|
| 1. Individual's Name:                         |                              |
| 2. Individual's Mailing or Email Address:     |                              |
| 3. Date of Birth:                             |                              |
| 4. Social Security Number:                    |                              |
| 5. Hours currently authorized:                |                              |
| 6. Hours used as of the date of this request: |                              |
| 7. Additional budget being requested:         | <i>See Grid on Back Page</i> |
| 8. Requested Start Date:                      | <i>See Grid on Back Page</i> |

9. Describe why the participant requires a budget increase. What is the current unmet care need?

10. Describe the services that will be provided if the request is granted and include the actual tasks or care to be delivered to the individual and how it will meet their goals.

11. Describe what other options have been explored (such as informal supports, Adult Day, consultation with Division for Blind and Visually Impaired, etc.) to meet the participants care needs/goals.

12. If a **retroactive start date** is being requested, explain the precipitating event that necessitated an immediate increase of services exceeding the currently approved volume of services. Include the date of the event and explain why the delay of request.

Case Manager's name: \_\_\_\_\_ Email: \_\_\_\_\_

Agency: \_\_\_\_\_ Phone number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Snail Mail request to:**

**Choices for Care Program, DAIL-ASD**

280 State Dr. HC 2 South

Waterbury, VT 05671-2070 or

**Fax: Moderate Needs Forms:** to 802-828-0599 **High/Highest Forms:** to (802) 241-0385

**ASD Team Decision:** ☐ Approve ☐ Deny ☐ Partial Approval

**Budget approved in this request:** \$ \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

**Total Budget for Calendar Year:** \$ \_\_\_\_\_ **Retroactive?** ☐ Yes or ☐ No

**LTCCC:** \_\_\_\_\_ **Prior Authorization needed?** ☐ Yes or ☐ No

**Copy to ARIS:** ☐ Yes or ☐ No

**DAIL Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructions for Respite/Companion Variance Requests CFC (High/Highest only):**

A prior-authorization for any approved additional respite/companion budget must be entered into the Medicaid Management Information System (MMIS) by DAIL-ASD. When requesting an increase in the budget for additional Respite/Companion services **please use the table below** to indicate the desired budget by each service. DAIL-ASD also needs to know during what time of the year the budget is being requested (how will it be distributed) because the prior-authorizations are done by the first and second six months of the year.

**Example:** \$1003.00 1/1/16 to 6/30/16 and \$8004.20 7/1/16 to 12/31/16 = Total annual budget of \$9007.20 (720hrs)

**Respite/Companion Budget Request Table: Requested Start Date:** \_\_\_\_\_

Service	Revenue Code	Requested Hours	Budget = # Hours X \$22.12	January 1 to June 30th	July 1 to December 31
<i>Respite</i> by <b>Home Health</b>	073		\$		
<i>Companion</i> by <b>Home Health</b>	073		\$		
			<b>Budget = # Hours X \$12.51</b>		
<i>Respite</i> by <b>Consumer</b> Directed Personnel	075		\$		
<i>Companion</i> by <b>Consumer</b> Directed Personnel	075		\$		
<i>Respite</i> by <b>Surrogate</b> Directed Personnel	080		\$		
<i>Companion</i> by <b>Surrogate</b> Directed Personnel	080		\$		

**Case Management Request (No Prior Authorization Needed): Requested Start Date:** \_\_\_\_\_

Service	Requested Hours	Budget = # Hours X \$69.40
<i>Case Management</i> <b>Home Health</b>		
<i>Case Management</i> <b>Area Agency on Aging</b>		

**ASD Team Use Only**

**Prior Authorization (PA) #** \_\_\_\_\_